Community Partners for Children
Travis County CRCG

CPC Authorization for Release of Protected Health Information

This authorization is voluntary and therefore you have the right to refuse to sign this authorization. By signing this authorization you are agreeing to participate in a collaborative meeting, potentially with some or all of the agencies listed below. You have the right to inspect and receive a copy of the CPC Referral Form and list of CPC Recommendations. You will receive a copy of this signed authorization.

If you choose not to sign this authorization then a CPC session for your family cannot be scheduled at this time. However, a CPC representative will contact you to discuss further options.

Child/Youth Name: _____

Date of Birth: _____

I authorize Community Partners for Children to obtain, provide, and exchange written, electronic, and verbal information regarding protected health information with the following agencies/organizations (parent/caregiver MUST initial next to each agency/organization for this form to be valid):

CPC Partner Agencies

____Any Baby Can
____ARC of the Capital Area
____Austin Child Guidance Center (ACGC)
____Austin Independent School District
____Centers for Children and Families
____Child & Adolescent Psychiatry, UT Austin, Dell Medical School
____Communities in Schools
____Community Volunteer (not agency affiliated)
____Parent and/or Youth Volunteer
____CPS Reintegration Project
____Del Valle Independent School District
____Integral Care (Austin Travis County)
____LifeWorks
____Maximus (Medicaid Managed Care)
____Pflugerville Independent School District
____Texas Child Study Center
____Texas Dept of Family & Protective Svs
____Texas Dept of State Health Services
____The Children's Partnership
____Travis County Health and Human Svs
____Travis County Juvenile Probation Dept
____TRIAD
____Vida Clinic
____Via Hope
____Other_____
____Other_____

Affiliated Agencies That Partner with CPC

____African American Youth Harvest Foundation (AAYHF)
____Austin Oaks Hospital
____Austin State Hospital
____Autism Society of Texas
____Capital Area Workforce Solutions/ WERC
____Cedar Crest Hospital & Residential Treatment Center
____Center for Child Protection
____Dell Children's Hospital
____Georgetown Behavioral Health Institute
____Manor Independent School District
____Meridell Achievement Center
____Out Youth
____Round Rock ISD
____SAFE Austin
____San Marcos Treatment Center
____Tx Health & Human Services Commission
____Texas Juvenile Justice Department
____Texas Network of Youth Services
____Texas NeuroRehab Center
____Texas Workforce Commission
____University High School
____Waco Center for Youth
____Other_____
____Other_____
____Other_____

To better understand the needs of your child and family it will be necessary to review the following types of information during your CPC Family Session. Please initial next to the information to be disclosed:

____CPC Referral Form (mandatory)
____Determination of Intellectual Disability
____Psychiatric Evaluation
____Treatment Plan
____Staff Progress Notes
____Diagnosis
____Psychological Assessment
____Juvenile Justice Records/Documentation
____Placement/Hospitalization Discharge Plan
____Medication Information
____Narrative Assessments
____Doctor Progress Notes
____School Records
____Special Education Documentation
____Other_____
____Other_____

I understand that this authorization extends to all information contained in my records about mental illness, developmental disabilities, chemical or alcohol dependency, communicable diseases such as HIV and AIDS, genetic information, and any other types of protected health information. **____ (initial)**

Information to be released should cover the time period from _____ to _____
If no time period given, the information released will cover all information prior to the expiration date of this authorization form.

This authorization can be cancelled at any time by submitting cancellation in writing to Community Partners for Children (mail to: Travis County HHS, Attn: Susie Kirk, PO Box 1748, Austin, Texas 78767 or fax: 512-854-5871). However, the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. All written materials are provided to CPC members on the day of the family's CPC session and are given only to designated CPC partners on the CPC Recommendations. Community Partners for Children cannot control how the protected health information will be used by the agency/person who receives it under this authorization. Please be advised that this consent includes communication by fax and email. The two methods are not always secure and CPC cannot ensure security by the other party.

Unless cancelled or otherwise specified, this authorization will expire one year from date of signature.
Other specified expiration date: _____

Legally Authorized Representative Signature (LAR/Parent/Legal Guardian):	**Date:**
Legally Authorized Representative Printed Name:	**Relationship to Child/Youth:**

Authorization explained to LAR and LAR signature witnessed by-

Referring Agency Representative: _____ Date: _____

(Please sign above and print name here): _____

Authorization Approved and Accepted by –

CPC Representative: _____ Date: _____